

FEB 17 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2892

Registration District No. 400

Primary Registration District No. 555213

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Jackson Township
(c) Name of hospital or institution Jackson County Home for the aged
(d) Length of stay: In hospital or institution 7 years
In this community 10 years

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson 48
(c) City or town Kansas City MO
(d) Street No. 809 Judy Ave
(e) If foreign born, how long in U. S. A. ? years

3. (a) PRINT FULL NAME Samuel Keiser

8. (b) If veteran, name war No 8. (c) Social Security No. None

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive years

7. Birth date of deceased May 10 1868

8. AGE: Years 72 Months 8 Days 4

9. Birthplace Ill. 1

10. Usual occupation House mover

11. Industry or business

12. Name W. J. McCarthy
13. Birthplace Ill. 9

14. Maiden name
15. Birthplace Ill. 9

16. (a) Informant W. J. McCarthy
(b) Address Little Blue, Mo.

17. (a) Burial (b) Date thereof Jan 19-41
(c) Place: burial or cremation Mt Hope

18. (a) Signature of funeral director Rose & Henderson
(b) Address 1115-41

19. (a) 1-15-41 (b) David J. Linnell

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 14 year 1941 hour 4 minute a.m.

21. I hereby certify that I attended the deceased from July 20th 1940 to Jan 14 1941 that I last saw him alive on Jan 14 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
3 days

Due to

Due to

Other conditions

Major findings: Of operations
Of autopsy

Duration 9 days

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence

(c) Where did injury occur?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

9 3 2
While at work (Specify type of place) (a) Means of injury

23. Signature David J. Linnell (M. D. or other) D
Address 1115-41 W. Walnut St. Date signed 1-14-41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1492

1112

REC-03

STATEMENT BY LICENSED EMBALMER

12-15-1914

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Leon H. Stewart
Licensed Embalmer No. 4177
P. O. Address Kansas City Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2892

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 400

Primary Registration District No. 555313

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Prairie
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Samuel Reises

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex m

5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years 72

Months 8

Days 4

If less than one day hr. min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

(b) Address

17. (a)

(b) Date thereof

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? years

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Jan day 14
year 1943 hour minute M.

21. I hereby certify that I attended the deceased from
19 to 19
that I last saw him alive on
and that death occurred on the date and hour stated above.

Immediate cause of death
Pneumonia
(Hypostatic) Broncho-pneumonia

Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature J. B. Bailey (M. D. or other)
Address 419-10-41 Date signed

419-10-41

